DEPARTMENT OF HEALTH

Ge-dibaabamind Awiya Otawagaang

Ezhi-wiinind a'aw abinoojiinh: _____

Apii gaa-ondaadizid: _____

Aaniin Weniijaanisiyeg/Genawenimegig abinoojiinyag:

Daa-dibaabamaawag ingiw abinoojiinyag epiichi-minotang omaa gikinoo'amaadiiwigamigong aabajichigaadenig inow inaakonigewinan gaa-ozhichigaadeg imaa Minnesota Department of Health. Mii i'iwapii ishkwaaj gaa-tibaabamind a'aw gidaabinoojiinyim _____/_____/____ naa gaye o'owapii _____/_____/____.

- Gaawiin ogii-nakwetanziin a'aw gidaabinoojiinyim gaa-pi-noondaagwakin gii-tibaabamind gii-izhi-nitaa-noondang gegoo. Nashke dabazhish agwaakobii'igan dabasayi'ii ayaamagak.

Pure Tone Audiometry – Right Ear	Initial Screen	Rescreen
500 Hz, 25 dB	PASS/REFER	PASS/REFER
1000 Hz, 20 dB	PASS/REFER	PASS/REFER
2000 Hz, 20 dB	PASS/REFER	PASS/REFER
4000 Hz, 20 dB	PASS/REFER	PASS/REFER
6000 Hz, 20 dB (ages 11 and up)	PASS/REFER	PASS/REFER
Pure Tone Audiometry – Left Ear	**Initial Screen**	**Rescreen**
500 Hz, 25 dB	PASS/REFER	PASS/REFER
1000 Hz, 20 dB	PASS/REFER	PASS/REFER
2000 Hz, 20 dB	PASS/REFER	PASS/REFER
4000 Hz, 20 dB	PASS/REFER	PASS/REFER
6000 Hz, 20 dB (ages 11 and up)	PASS/REFER	PASS/REFER

- Mii onow ge-gikenjigaadenig giishpin ani-bishkotang gidaabinoojiinyim.
- Gidaa-izhiwinaa gidaabinoojiinyim iwidi mashkikii-wigamigong da-dibaabamind da-gikenjigaadenig ezhi-minotang.(Bizindamoo-mashkikiiwinini).
- Giishpin ayigwa ganawenimigod gidaabinoojiinyim epiichi-minotang, gemaa gaye giishpin misawenimad awiya da-wiidookook ani-nandawaabamad aya'aa a'aw bizindamoo-mashkikiiwinini, daga wiindamaw a'aw mashkikiiwikwe gikinoo'amaadiiwigamigong.
- Daga miizh a'aw gibizidamoo-mashkikiiwinini o'ow mazina'igan da-gikenjigaadang gaa-izhi-dibaabamimind a'aw gidaabinoojiinyiman omaa gikinoo'amaadiiwigamigong.
- Giishpin wii-kagwedweyan gegoo gemaa misawenimad awiya da-wiidookook nandawaabamad a'aw bizindamoo-mashkikiiwinini, daga ganoozhishinaang.
- _____

Health Care Provider, please complete this form.

Child's Name: _____ Date of Birth: _____

School Name: _____

Provider comments:

I have examined this child on_____/_____/_____ and find the following:

MEDICAL:

- ☐ Hearing (circle): PASS or REFER
- ☐ Medically treatable
- ☐ Not medically treatable
- ☐ Outer Ear
- ☐ Middle Ear
- ☐ Inner Ear
- ☐ Refer to Audiology

Further Comments: _____

_____

_____

Recommendations to support learning in the school environment: _____

_____

_____

AUDIOLOGICAL:

- ☐ Normal Hearing
- ☐ Conductive Hearing Loss
- ☐ Mixed Hearing Loss
- ☐ Sensorineural Hearing Loss
- ☐ Refer to Physician
- ☐ Amplification Evaluation

Further Comments: _____

_____

_____

Recommendations to support learning in the school environment: _____

_____

_____

Child should return for follow up examination on _____

Provider Name/Title: _____

Contact Information _____

Schools nurse or health staff fill out this section below before sending home.

Please have the parent return this form to the school or you can return this to:

School Nurse Name: _____

Phone: _____

Address: _____

_____

Email: _____

This templated form was developed by MDH for use in schools.

Minnesota Department of Health
Abinoojiinyag naa Weshkaya'aajig debaabaminjig
Giigidowin:651-201-3650
Iibii'igewin: health.childteencheckups@state.mn.us
Waasamoo-asabiing: www.health.state.mn.us

02/2023

Wii-ayaaman o'ow ozhibii'igan, daga ganoozhishinaang: 651-201-3650.